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MOTION FILED

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No. 98-1949

IN THE
Supreme Court of the United States

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION and
HEALTH ALLIANCE MEDICAL PLANS, INCORPORATED

Petitioners,

v.

CYNTHIA HERDRICH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

**MOTION OF THE AMERICAN ASSOCIATION OF
HEALTH PLANS, THE HEALTH INSURANCE
ASSOCIATION OF AMERICA, THE ASSOCIATION OF
PRIVATE PENSION AND WELFARE PLANS, AND THE
CHAMBER OF COMMERCE OF THE UNITED STATES
FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT
OF PETITIONERS AND BRIEF *AMICI CURIAE***

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Pursuant to Rule 33.1 of the Rules of the Supreme Court, Amici, the American Association of Health Plans ("AAHP"), the Health Insurance Association of America ("HIAA"), the Association of Private Pension and Welfare Plans ("APPWP"), and the Chamber of Commerce of the United States (the "Chamber") hereby move for leave to file the attached brief Amici Curiae.

Counsel for Petitioners-Appellants, Virginia Seitz, Esq. of the law firm of Sidley & Austin, 1722 Eye Street, N.W., Washington, D.C. 20006, has given permission for Amici to file a supporting brief. Counsel for Respondent-Appellee, James Ginzkey, Esq. of the law firm of Hayes, Miles, Cox and Ginzkey, 202 North Center Street, P.O. Box 3067, Bloomington, Illinois 61702-3067, has refused to give permission for Amici to file such a brief. The reasons for filing of this Amicus Brief are succinctly set forth below.

AAHP is a national association for the managed health care community. Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* ("ERISA").

HIAA is a national association for private health insurance companies and is an advocate for the private, market-based health insurance system. Its more than 225 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 110 million Americans.

The APPWP is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers, and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants.

The Chamber is the world's largest business federation representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. One of the Chamber's functions is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of tremendous importance to the Chamber's member organizations.

As representatives of the health plan, health insurance, and business community, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of AAHP, HIAA, APPWP, and the Chamber provide health benefits to employees and arrange for the provision of health care services to employee benefit plans regulated under ERISA. Further, many of the Chamber's and APPWP's member organizations are purchasers of health care services.

The Seventh Circuit's holding that benefit design features (here, an HMO's use of legal cost-containment measures), can violate the fiduciary duty provisions of ERISA will have a dramatic effect on the ability of the employee benefit plan community and the health care industry to control costs while providing quality care. Creating ERISA liability for common plan design features will drive up the cost of health care coverage and will discourage employers from purchasing managed care services or insurance products, or from otherwise providing health care coverage to their employees.

AAHP, HIAA, APPWP, and the Chamber believe that they can show this Court that the Seventh Circuit's decision will have a substantial negative impact on the way their member organizations administer and structure the delivery of health care services to employee benefit plans, to the detriment of affordable, quality health care.

WHEREFORE, AAHP, HIAA, APPWP, and the Chamber respectfully request leave to file the accompanying brief as Amici Curiae.

Respectfully submitted,

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TABLE OF CONTENTS

	<i>Page</i>
Table of Cited Authorities	ii
Table of Appendices	vii
Statement of Interest	1
Summary of Argument in Support of Appellants' Petition for Writ of Certiorari.	3
Argument	4
A. Introduction	4
B. The Court of Appeals' Holding Imposes Unnecessary Burdens on Employee Benefit Plans	7
C. Financial Incentive Arrangements in Managed Care Are Beneficial to Both Patients and Physicians	10
D. The Decision Below Contravenes Uniform Federal and State Policy Permitting Cost Containment Measures in Health Plans	13
E. ERISA Does Not, and Should Not, Provide an Alternate Remedy for Medical Malpractice	18
Conclusion	20

TABLE OF CITED AUTHORITIES

	<i>Page</i>
Cases:	
<i>American Federation of Musicians v. Wittstein</i> , 379 U.S. 171 (1964)	4
<i>Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc.</i> , 472 U.S. 559 (1985)	19
<i>DeLucia v. Saint Luke's Hosp.</i> , No. 98-6446, 1999 U.S. Dist. LEXIS 8124 (E.D. Pa. May 24, 1999)	20
<i>Neade v. Portes</i> , 710 N.E.2d 418 (Ill. App. Ct. 1999)	20
<i>Patterson v. Lamb</i> , 329 U.S. 539 (1947)	4
<i>United States v. Ruzicka</i> , 329 U.S. 287 (1946)	4
<i>Varity Corp. v. Howe</i> , 516 U.S. 489 (1996)	19
Statutes:	
29 U.S.C. § 1001, <i>et seq.</i>	1
29 U.S.C. § 1104(a)(1)	8, 14
29 U.S.C. § 1109	19

Cited Authorities

	<i>Page</i>
29 U.S.C. § 1132(a)(3)	19
29 U.S.C. § 1133	15
29 U.S.C. § 1171	16
42 U.S.C. § 300(e)	14
42 U.S.C. § 300(e)(b)(1)	14
42 U.S.C. § 300(e)(c)(2)(D)	14
42 U.S.C. § 300gg	16
42 U.S.C. § 300gg-41	16
42 U.S.C. § 1395mm	16
42 U.S.C. § 1395w	16
42 U.S.C. § 1396b(m)	16
CAL. HEALTH & SAFETY CODE § 1348.6 (West 1999)	16
FLA. STAT. ANN. § 627.4234	15
FLA. STAT. ANN. §§ 641.17, <i>et seq.</i>	15
215 ILL. COMP. STAT. 125/1-1 <i>et seq.</i>	15

Cited Authorities

	Page
N.J. ADMIN. CODE tit. 26, § 2H-18.51 (West 1997)	16
N.J. STAT. ANN. §§ 26:2J-1, <i>et seq.</i>	15
TEX. INS. CODE ANN. art. 20A.01, <i>et seq.</i>	15
Pub. L. No. 99-509, § 9313, 100 Stat. 2002	15
Pub. L. No. 101-508, §§ 4204(a), 4731, 104 Stat. 1388-108, -195	15
Pub. L. No. 104-191, 110 Stat. 2945	16
Pub. L. No. 104-204, 110 Stat. 2935, §§ 603, 604 .	16
Pub. L. No. 105-277, § 902, 112 Stat. 2681	16

Other Authorities Cited:

AMERICAN ASSOCIATION OF HEALTH PLANS, THE REGULATION OF HEALTH PLANS 11 (1998)	14
David W. Bates, David J. Cullin, Nan Laird, et al., <i>Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention</i> , 274 JAMA 29 (1995)	11
Donald M. Berwick, <i>Payment by Capitation and the Quality of Care</i> , 335 NEW ENG. J. MED. 1227 (1996)	12

Cited Authorities

	Page
Paula Breveman, <i>Insurance Related Differences in the Risk of Ruptured Appendix</i> , 331 NEW ENG. J. MED. 444 (1994)	12, 13
WILLIAM S. CUSTER, HEALTH INSURANCE ASSOCIATION OF AMERICA, HEALTH INSURANCE COVERAGE AND THE UNINSURED 3 (1999)	6, 7
STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999)	5, 6
HEALTH INSURANCE ASSOCIATION OF AMERICA, MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE, PART A, 228 (1996)	10
Fred J. Hellinger, <i>The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence</i> , 53 MEDICAL CARE RESEARCH & REVIEW 294 (1996)	11
Alan L. Hillman, et al., <i>How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?</i> , 321 NEW ENG. J. MED. 86 (1989)	12

Cited Authorities

	<i>Page</i>
Peter T. Kilborn, <i>Insurers Raise Health Coverage Costs to New Highs</i> , THE TOPEKA CAPITAL-JOURNAL, December 20, 1998	5
N.Y. PUB. HEALTH LAW § 4400 (McKinney 1999)	14
Patients' Bill of Rights Plus Act, S. 1344, 106 th Cong. (1999)	18
REPORT TO THE PRESIDENT OF THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS 156 (1998)	11
Gerald F. Riley, <i>Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees</i> , 84 AM. J. PUB. HEALTH 1598 (1994)	13
KENNETH E. THORPE, NATIONAL COALITION ON HEALTH CARE, THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING 1 (1997)	6
57 FED. REG. 59,024	15
42 C.F.R. § 417.479	15

TABLE OF APPENDICES

	<i>Page</i>
Appendix — Compilation Of Relevant Studies And Articles	1a

STATEMENT OF INTEREST

The American Association of Health Plans ("AAHP") is a national association for the managed health care community.¹ Its membership includes health maintenance organizations, preferred provider organizations, third party health benefits administrators, health care utilization review organizations, prepaid limited health service plans, and other integrated health care delivery systems. AAHP represents more than 1000 health plans serving nearly 140 million Americans, the majority of whom are participants or beneficiaries of employee benefit plans under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*

The Health Insurance Association of America ("HIAA") is a national association for private health insurance companies and an advocate for the private, market-based health insurance system. Its more than 225 members provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to 110 million Americans.

The Association of Private Pension and Welfare Plans ("APPWP") is a broad based, non-profit trade association founded to protect and foster the growth of this Nation's privately sponsored employee benefit plans. The members of APPWP include both small and large employer sponsors of employee benefit plans, as well as plan support organizations, such as consulting and actuarial firms,

1. Counsel for the Amici were the sole authors of this brief. No person or entity other than Amici made a financial contribution to this brief.

investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans which cover more than 100 million plan participants.

The Chamber of Commerce of the United States (the "Chamber") is the world's largest business federation, representing an underlying membership of more than three million businesses and organizations of every size, in every sector and region. One of the Chamber's functions is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the business community. The ability of its member organizations to both provide and purchase affordable, quality healthcare is of vital importance to the Chamber's member organizations.

As representatives of the health plan, health insurance and business community, AAHP, HIAA, APPWP, and the Chamber have a strong interest in the federal questions presented by this case under ERISA. The member organizations of Amici provide health benefits to employees or arrange for the provision of health care services to employee welfare benefit plans regulated under ERISA. Further, many of the APPWP's and the Chamber's member businesses are purchasers of health care services.

Amici have joined together to file this brief in support of the Petition for Certiorari because of the court of appeals' novel interpretation of ERISA and that statute's established body of caselaw, as well as the extraordinary significance that the holding will have on sponsors of employee welfare benefit plans and health insurance issuers. Counsel for Appellants, Virginia Seitz, Esq., of the law firm of Sidley &

Austin, has given her consent for Amici to file this brief. Counsel for Appellee, James Ginzkey, Esq., of the law firm of Hayes, Miles, Cox and Ginzkey, has refused to give permission for Amici to file this brief.

The Seventh Circuit's holding that health plan benefit design features, such as an HMO's use of legal cost-containment measures, can violate the fiduciary duty provisions of ERISA, will have a dramatic effect on the ability of the employee benefit plan community and the health care industry to control costs while providing quality care. Creating ERISA liability for common plan design features will drive up the cost of health care coverage and will discourage employers from purchasing managed care services or insurance products, or from otherwise providing health care coverage to their employees.

SUMMARY OF ARGUMENT IN SUPPORT OF APPELLANTS' PETITION FOR WRIT OF CERTIORARI.

The holding of the Seventh Circuit Court of Appeals threatens the ability of employers to provide comprehensive health benefits to the over 160 million Americans receiving health coverage through their employment. In essence, the lower court's holding, if it is allowed to stand, subjects normal and necessary cost containment mechanisms included in all health plans to challenge under both state tort law and ERISA, notwithstanding the fact that such cost containment measures are expressly encouraged and often are mandated by both state and federal laws and regulations.

Moreover, the lower court's holding is a novel interpretation of ERISA's fiduciary provisions that will have

far reaching negative consequences for the employer sponsored benefit plan community, the health insurance industry, and the American public. The decision below does violence to both the intent and text of ERISA because it (1) discourages employers and others from maintaining benefit plans, inevitably increasing the ranks of the uninsured, and (2) creates a new tort for "breach of fiduciary duty" that finds no basis in ERISA.² The result is an arrogation of power to the courts that Congress intended be left in private hands.

ARGUMENT

A. Introduction

In an unprecedented decision, the Seventh Circuit has transformed a garden-variety medical malpractice case into a serious threat to the cost-containment measures of health insurance issuers and of employee benefit plans, whether they are self-insured, insured through managed care organizations ("MCOs"), or sponsored by governmental entities such as Medicare. The facts, as alleged by plaintiff Cynthia Herdrich, illustrate a classic example of improper medical judgment. Lori Pegram, a physician employed by the petitioner Carle Clinic Association, examined Ms. Herdrich. Although a mass was discovered in her abdomen, an eight-day delay in providing her with a sonogram resulted in a ruptured appendix and peritonitis. In a separate action,

2. See, e.g., *American Federation of Musicians v. Wittstein*, 379 U.S. 171, 175 (1964) (certiorari appropriate where question presented is an important one of first impression under a statute); *United States v. Ruzicka*, 329 U.S. 287, 287 (1946) (certiorari appropriate where decision significantly affects the administration of a statute); *Patterson v. Lamb*, 329 U.S. 539, 541 (1947) (certiorari appropriate where many individuals are affected by decision below).

an Illinois jury awarded Ms. Herdrich damages of \$35,000 against Dr. Pegram for medical malpractice.

A divided panel of the Seventh Circuit improperly transformed that state-law based malpractice claim into a breach of fiduciary duty claim under ERISA. The majority held that the mere allegation that an HMO or its physicians implements cost-containment mechanisms that include physician inducements states a claim for breach of fiduciary duty under ERISA.

Currently, 160 million non-elderly Americans depend upon privately sponsored employer health and welfare plans subject to ERISA for their health care coverage.³ Employers, after a period of relatively stable health care costs, are once again facing health care inflation. Consequently, they are beginning to withdraw their economic support of health and welfare plans, or are limiting their contributions to fixed amounts, thus passing the inflationary burden to their employees. As a result, the number of Americans who are without health care coverage has increased, and is projected to increase further if appropriate action is not taken.⁴

This decision, if not overturned, will be devastating to current efforts by Congress, the Executive Branch, and the private sector to contain health care costs while attempting

3. See Peter T. Kilborn, *Insurers Raise Health Coverage Costs to New Highs*, THE TOPEKA CAPITAL-JOURNAL, December 20, 1998; see also STEVEN FINDLAY & JOEL MILLER, NATIONAL COALITION ON HEALTH CARE, DOWN A DANGEROUS PATH: THE EROSION OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES 4 (1999) (stating that 61% of Americans receive health care coverage through their employer).

4. See FINDLAY & MILLER, *supra* note 3, at 5.

to strike the proper balance between cost control incentives and responsibility to patients. This broadside attack, unfortunately, comes at a time when the number of uninsured Americans is rising and when health care costs are continuing their ascent.

At present, 43 million Americans remain uninsured⁵ and projections are that one million additional people will become uninsured each year, despite the burgeoning growth in the United States economy.⁶ Economic and political factors have curtailed the availability of alternate governmental sources of health care coverage such as Medicaid and Aid to Families with Dependent Children.⁷ As health care costs continue to rise (they are projected to reach \$1.5 trillion annually by 2002),⁸ Congress and the state legislatures are desperately searching for alternative ways to assure coverage, and are considering measures such as additional tax credits for health insurance premiums and grants to low income families to buy insurance. The Seventh Circuit's decision is counter to that trend, as it will severely limit this country's ability to maintain, much less to expand, health care

5. See *id.* at 1; see also WILLIAM S. CUSTER, HEALTH INSURANCE ASSOCIATION OF AMERICA, HEALTH INSURANCE COVERAGE AND THE UNINSURED 3 (1999) (same).

6. See KENNETH E. THORPE, NATIONAL COALITION ON HEALTH CARE, THE RISING NUMBER OF UNINSURED WORKERS: AN APPROACHING CRISIS IN HEALTH CARE FINANCING 1 (1997); see also CUSTER, *supra* note 4, at 5 (estimating that approximately fifty-three million Americans will be uninsured by 2007).

7. See FINDLAY & MILLER, *supra* note 3, at 10.

8. See THORPE, *supra* note 6, at 2.

coverage, and to prevent a return to the health care cost hyperinflation of the 1970s and 1980s.⁹

The court of appeals' decision exacerbates the crisis by effectively exempting medical professionals alone from the necessary discipline of the marketplace. Only Judge Flaum, in dissent, recognizes the economic reality that private and public efforts to contain health care costs are necessary, and that those efforts must include all sectors of the health care industry, including medical professionals.¹⁰ The alternative is unacceptable: a return to "open checkbook" medical reimbursement. The dissent also correctly points out that both federal and state law are replete with measures allowing or even mandating cost-containment measures, and that supervision of employer-sponsored benefit plans and managed care constitutes a legislative and regulatory function that the courts are ill-equipped to perform.

B. The Court of Appeals' Holding Imposes Unnecessary Burdens on Employee Benefit Plans

The court of appeals' decision makes it impossible for anyone to design or administer benefit plans without the risk of becoming an ERISA plan fiduciary, subject to being continuously second-guessed and penalized by plaintiffs and courts. In enacting ERISA, Congress did not intend the federal courts to substitute their views of what constitutes appropriate plan design for the judgments of employers and

9. See CUSTER, *supra* note 5, at 4-5.

10. See *Herdrich v. Pegram*, ("Herdrich"), 154 F.3d 362, 380-384 (7th Cir. 1998) (Flaum, J., dissenting), *reh'g en banc denied*, 170 F.3d 683 (7th Cir. 1999), *petition for cert. filed*, (U.S. June 4, 1999) (No. 98-1949).

plan sponsors. The appropriate judicial inquiry is: *In administering the plan, has there been a breach of ERISA's fiduciary duties?* The duty of an ERISA fiduciary is to implement a plan in accordance with that plan's design and in accordance with that fiduciary's own best judgment.¹¹ After *Herdrich*, courts now have authority to engage in the following inquiry, sanctioned by the Seventh Circuit: *Does a court believe that a plan design might be unfair or might harm a plan member?*

Not only does the Seventh Circuit's decision arrogate to the courts the right to second-guess plan design, but it establishes an unprecedented and dangerous principle of ERISA fiduciary liability. That principle can be summarized as follows: *Any entity that administers any aspect of a deficient or unfair plan or who exercises a professional judgment which affects the provision of benefits is thereby rendered a plan fiduciary. Moreover, where the professional judgment is negligently made, that negligence will constitute a breach of fiduciary duty.*

As Judge Easterbrook remarked in his dissent from the Seventh Circuit's denial of rehearing *en banc*, the decision has far-reaching consequences:

If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of

11. Employee Retirement Income Security Act of 1974 (ERISA), § 404(a)(1), 29 U.S.C. § 1104(a)(1) (1974).

profit from cost-reducing strategies) . . . are the principal features of HMOs and "preferred provider organizations."¹²

Those features, all designed to control the cost of providing health care benefits, have traditionally not been subject to judicial review. *Herdrich*, however, allows a plaintiff to challenge every single decision made in the context of establishing or administering a health plan, including:

- *Decisions respecting structural and administrative issues.* Routine business judgments, such as the selection of a specific health care delivery system and what form that entity will take, could now be subject to claims of fiduciary breach.
- *Decisions respecting benefit design and delivery.* All plans exclude or limit certain benefits for cost reasons, limiting benefits to "medically necessary" care or excluding coverage for cosmetic surgery. The court of appeals' opinion allows such decisions to be challenged as a "breach of fiduciary duty."
- *Decisions of physicians and other health professionals respecting the appropriate type and level of care.* Questions such as whether a person needs to be hospitalized, or whether a child needs Tylenol or a stronger drug to control pain, will all be transformed into fiduciary decisions.

12. *Herdrich v. Pegram*, 170 F.3d 683, 687 (7th Cir. 1999) (Easterbrook, J., dissenting).

It is hard to exaggerate the enormous adverse impact that the decision is likely to have on employee benefit plans and health care providers if left unreviewed. If employers, plan administrators, and health professionals are subject to liability for selection of a health care delivery system and plan design, there will be an increase in litigation. The fear of the associated liability and increase in costs will decrease the likelihood that health insurance issuers will be able to provide cost-effective, comprehensive products, and that employers will continue to provide employees with health care coverage.

C. Financial Incentive Arrangements in Managed Care Are Beneficial to Both Patients and Physicians

Compensation arrangements that reward providers and consumers for achieving cost savings while delivering high quality care are a cornerstone of the American health care delivery system. Over the last decade, in an effort to control costs, traditional fee-for-service medicine has largely been replaced by a variety of forms of managed care, premised on encouraging both providers and enrollees to use limited health care dollars prudently. Such financial incentives for *providers* include risk-sharing arrangements such as payments on a capitated basis, provider withholds, discounted fees with bonuses, and global rates.¹³ For health care *consumers*, they

13. Capitation is "a method of payment in which a provider is paid a fixed amount for each enrollee regardless of the actual number or nature of services provided." HEALTH INSURANCE ASSOCIATION OF AMERICA, *MANAGED CARE: INTEGRATING THE DELIVERY AND FINANCING OF HEALTH CARE*, PART A, 228 (1996). Withhold arrangements refer to "a portion of a provider's salary, fees, or capitation that is held back until performance in relation to quality and utilization are examined at the end of year." *Id.* at 240. Global rates allow certain procedures (such as expensive organ transplants) to be reimbursed at a single rate to include all professional and facility services. *See id.* at 230.

include responsibility for a portion of the bill through the almost universal use of deductibles and co-payments.

The court of appeals' view that physician incentive arrangements substantially erode the quality of American health care is contrary to every objective study of the issue. Financial incentives did not spring up with the advent of managed care. In fee-for-service medicine, for example, "there is a financial incentive to provide more services"¹⁴—perhaps even unnecessary services. More services, however, do not equate to better medical care, since they could be services that subject patients to a significant risk of complications and correlative diseases.¹⁵ The problem is serious: the recent report of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry has estimated that overutilization of medical services might "be as high as 30% of the total health care delivered in the United States."¹⁶

Not only does the empirical evidence indicate that physician incentive arrangements are actually effective in

14. Fred J. Hellinger, *The Impact of Financial Incentives on Physician Behavior in Managed Care Plans: A Review of the Evidence*, 53 MEDICAL CARE RESEARCH & REVIEW 294, 294 (1996).

15. *See* David W. Bates, David J. Cullin, Nan Laird, et al., *Incidence of Adverse Drug Events and Potential Adverse Drug Events: Implications for Prevention*, 274 JAMA 29, 29 (1995) (stating that "over a million patients are injured in hospitals each year, and approximately 180,000 die annually as a result of these injuries").

16. REPORT TO THE PRESIDENT OF THE ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, *QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS* 156 (1998).

limiting costs,¹⁷ but, more importantly, there are absolutely no definitive data supporting the court of appeals' position that reimbursement incentives exert a negative impact on overall quality of care. In fact, the opposite is true: "the literature in this area, including large studies of Medicaid and Medicare patients in managed care systems in the 1980s, consistently shows that *costs are lower in managed-care systems, with quality equal to or better than that in fee-for-service care.*"¹⁸

Statistically, for example, individuals like Ms. Herdrich who are suffering from appendicitis fare better in an HMO than in traditional fee for service plans.¹⁹ A study published in the New England Journal of Medicine revealed that ruptured appendices occurred in 34.3 percent of uninsured patients, 33.6 percent of Medicaid patients, 29.3 percent of patients with private insurance and in only 25.8 percent of the patients receiving care through managed care organizations.²⁰ Thus, the unsupported basis for the court of appeals' opinion — an assumption that managed care physicians are likely to sacrifice patient care for their pocketbook — is in direct conflict with the results of this

17. See Alan L. Hillman, et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989).

18. Donald M. Berwick, *Payment by Capitation and the Quality of Care*, 335 NEW ENG. J. MED. 1227, 1228 (1996) (*emphasis added*).

19. See Paula Breveman, *Insurance Related Differences in the Risk of Ruptured Appendix*, 331 NEW ENG. J. MED. 444, 444 (1994).

20. See *id.* at 446.

empirical study which found that to a "significant extent, patients covered by fee-for-services plans . . . appear to be at a disadvantage as compared to those covered by capitated private plans."²¹ The court of appeals, however, cites only articles and studies attacking managed care, while by-passing the many studies that praise managed care entities, especially with respect to their role in providing services to vulnerable populations and in reducing the incidence of fatalities from many forms of cancer.²²

A significant benefit of a capitated system is that it transfers more control over medical decision-making to the hands of treating physicians, rather than leaving such decisions to the financing entity. The court of appeals' assumption that financial incentives will cause physicians to ignore their professional and ethical obligations does a disservice to the profession while crippling benefit plan sponsors attempting to make the most of limited health care dollars.

D. The Decision Below Contravenes Uniform Federal and State Policy Permitting Cost Containment Measures in Health Plans

The court of appeals' disdain for cost containment mechanisms is not shared by either Congress or the state legislatures. The forms of financial risk sharing it condemns

21. *Id.* at 449.

22. See Gerald F. Riley, *Stage of Cancer at Diagnosis for Medicare HMO and Fee-for-Service Enrollees*, 84 AM. J. PUB. HEALTH 1598, 1598 (1994) (Medicare patients in HMOs are diagnosed with such cancers as breast, cervix, colon, and melanomas at an earlier stage as compared with fee-for-service enrollees).

are firmly grounded in legislative policy designed to eliminate the reverse incentives of "open checkbook" medicine. Systems of cost-savings have constituted the keystone of federal and state health care programs for the past quarter century. For example, the Federal Health Maintenance Organization Act of 1973²³ expressly authorizes HMOs to "make arrangements with physicians . . . to assume all or part of the financial risk."²⁴ Further, ERISA specifically proscribes to plan fiduciaries the duty to defray plan expenses and to preserve and maintain plan assets.²⁵

The court of appeals' diatribe against managed care is astonishing, given that every state as well as the District of Columbia regulates MCOs, either through a specific MCO statute or through its general insurance statute,²⁶ and relies on the expansion of HMOs and other forms of managed care to provide a "new alternative for the delivery of a full range of health care services *at a reasonable cost*."²⁷ A health plan may be self-insured and regulated under ERISA, or may be insured through an HMO, a preferred provider organization (PPO), or a combination such as a "point of service" (POS)

23. 42 U.S.C. § 300(e) (1973). The Act defines an HMO as a public or private entity that provides health services to enrollees *at a fixed cost*, without relation to the frequency, extent, or kind of health service actually furnished. 42 U.S.C. § 300(e)(b)(1).

24. 42 U.S.C. § 300(e)(c)(2)(D) (Supp. 1999).

25. ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1).

26. AMERICAN ASSOCIATION OF HEALTH PLANS, *THE REGULATION OF HEALTH PLANS* 11 (1998).

27. N.Y. PUB. HEALTH LAW § 4400 (McKinney 1999) (*emphasis added*).

plan, and thus subject to state mandated cost-control measures, with detailed requirements respecting patient deductibles, audits of bills, and utilization review of medical claims.²⁸ Both self-insured and insured plans must comply with regulatory monitoring systems to ensure quality assurance standards for the care provided to enrollees, to ensure adequate disclosure to enrollees regarding the benefits and conditions of the plan, and to provide for a fair appeals and grievance procedure.²⁹

Congress itself formerly shared the court of appeals' bias against MCO cost containment practices, and at one time prohibited prepaid health care organizations that contracted with Medicare and Medicaid from making incentive payments to physicians.³⁰ Research studies by the Department of Health and Human Services, however, "failed to find a link between the quality of care provided under the Medicare and Medicaid programs and the structure of physician incentive plans."³¹ Today, given the critical

28. See, e.g., ERISA § 503, 29 U.S.C. § 1133; FLA. STAT. ANN. § 627.4234 (West 1999).

29. See, e.g., FLA. STAT. ANN. §§ 641.17, *et seq.*; 215 ILL. COMP. STAT. 125/1-1 *et seq.*; N.J. STAT. ANN. §§ 26:2J-1, *et seq.*; TEX. INS. CODE ANN. art. 20A.01, *et seq.*

30. Omnibus Budget Reconciliation Act (OBRA) of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. 2002. The Omnibus Budget Reconciliation Act (OBRA) of 1990, Pub. L. No. 101-508, §§ 4204(a), 4731, 104 Stat. 1388-108, -195, repealed the prohibition on physician incentive plans in Medicare and Medicaid HMOs.

31. Medicare and Medicaid Programs: Requirements for Physician Incentive Plans in Prepaid Healthcare Organizations, 57 FED. REG. 59,024 (proposed Dec. 14, 1992); Requirements for Physician Incentive Plans, 42 C.F.R. § 417.479 (1997).

necessity of medical cost control, physician incentives are aggressively promoted in both the Medicare and Medicaid programs as a cost conservation measure.³²

While provider incentive programs and other cost-containment mechanisms are now expressly encouraged, they also are subject to extensive regulation to protect enrollees. Congress limited the use of one common cost-containment mechanism — pre-existing condition exclusions — in the Health Insurance Portability and Accountability Act of 1996,³³ and has enacted recent legislation prohibiting physician incentives to limit care in specified situations.³⁴ Some states also have specifically forbidden arrangements between a health plan and healthcare providers whereby payments are made as an inducement for the provider to “deny, reduce, limit or delay specific, medically necessary and appropriate services.”³⁵ Health plans are held accountable for their decisions not only by such laws, but also by private accreditation agencies, such as the non-profit National

32. Social Security Act, 42 U.S.C. § 1395mm (Supp. 1999) (Medicare managed care); 42 U.S.C. § 1396b(m) (Supp. 1999) (Medicaid managed care); 42 U.S.C. § 1395w (Supp. 1999) (Medicare+Choice).

33. Health Insurance and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191, 110 Stat. 2945; ERISA § 701, 29 U.S.C. § 1171; Public Health Service Act, §§ 2701, 2741, 42 U.S.C. §§ 300gg, 300gg-41.

34. *See* Newborns’ and Mothers’ Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935, §§ 603, 604; Women’s Health and Cancer Rights Act, Pub. L. No. 105-277, § 902, 112 Stat. 2681.

35. CAL. HEALTH & SAFETY CODE § 1348.6 (West 1999); *see also* N.J. ADMIN. CODE tit. 26, § 2H-18.51 (West 1997) (same).

Committee for Quality Assurance, which provides information enabling both plan sponsors and consumers of managed care to evaluate plans based on the quality of care provided.³⁶

There are few, if any, more highly regulated areas of the United States economy than employer-sponsored health care and the managed care industry. Yet the Seventh Circuit has concluded that all of the legislative and regulatory safeguards surrounding managed care’s relationship with ERISA plans are inadequate to protect consumers. There is no principled distinction between the court of appeals’ treatment of managed care organizations as particularly susceptible to financial-based conflicts involving decisions to provide care, and the conflicts present in the employer-financed health care industry or traditional fee-for-service insurance industry.³⁷

The court of appeals has disregarded both the considered judgment of Congress and the state legislatures that cost containment in health care is a necessity, as well as the myriad protections built into the system for health care consumers. On the basis of undocumented assumptions about the alleged adverse impact of MCO cost containment practices, the court has turned a virtue — the duty of an ERISA fiduciary to be financially prudent — into a punishable sin, with dire consequences for the limited health care dollars of every plan. Congress and state legislatures

36. The NCQA both accredits managed care plans in such areas as quality improvement, physician credentials, preventive health services, and utilization management, and provides specific performance measurement of plans using the Health Plan Employer Data and Information Set (HEDIS).

37. *See Herdrich*, 154 F.3d at 382 (Flaum, J. dissenting).

have determined that cost containment practices, properly structured and regulated, do not compromise the quality of medical care. Should it ever appear that some of those practices do have such an effect, then those legislatures have the authority and ability to step in to effect an appropriate cure.³⁸ The *Herdrich* majority's anti-managed care bias should not be allowed to override the carefully considered decision of the legislative and executive branches to promote the prudent and effective management of health plans.

E. ERISA Does Not, and Should Not, Provide an Alternate Remedy for Medical Malpractice

The court of appeals decision improperly equates ERISA fiduciary standards to medical malpractice standards, even though (1) ERISA does not allow any such equation, and (2) state tort law already provides relief if physicians render substandard care, just as Ms. Herdrich here was awarded damages for malpractice.³⁹

The *Herdrich* decision has unfortunately converted an ordinary tort claim into an unprecedented tort-based "breach of fiduciary duty" claim under ERISA. This is not a benign invention. By elevating the fiduciary duty owed to the individual participants of an employee benefit plan far above the duty owed to the plan as a whole, the decision literally prevents fiduciaries from fulfilling their statutory duty to

38. For example, Congress is currently debating enactment of a Patients' Bill of Rights Act providing additional protections for consumers. See Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. (1999).

39. See *Herdrich*, 154 F.3d at 367.

preserve and maintain plan assets.⁴⁰ The result: fiduciaries will be compelled to breach their statutory duties, as they are forced to purchase or administer plans without cost containment measures to appease individual plan members and to avoid liability for damages under this new judicially-created ERISA tort action. In the long run, of course, such an approach is counterproductive, as it depletes plan assets and inevitably places the health of those same plan members at serious risk.

There is no basis whatsoever in the text of statute or this Court's prior opinions for this novel tort-based "breach of fiduciary duty" claim, and this Court should not allow a court of appeals to create one. Although Ms. Herdrich purported to bring her claim "on behalf of the Plan,"⁴¹ no financial loss to the Plan flowed from Dr. Pegram's delay in scheduling Ms. Herdrich for medical services, and her personal loss provides no basis for remedial relief for the Plan under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3). Nor can Ms. Herdrich rely on Section 409 of ERISA, 29 U.S.C. § 1109, which allows participants to bring claims against a plan fiduciary who causes injury to the plan, and requires that the breaching fiduciary "make good to such plan losses to the plan." Nowhere in Ms. Herdrich's complaint does she allege that *any* action on the part of the HMO caused a financial loss to "the Plan," and indeed she cannot. The Plan would have realized a financial gain rather than a loss if it functioned as Ms. Herdrich alleged. Any cost savings realized as a result of physician incentives would necessarily *reduce*

40. See *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); see also *Central States, Southeast & Southwest Areas Pension Fund v. Central Transp., Inc.*, 472 U.S. 559, 569-70 (1985).

41. See *Herdrich*, 154 F.3d at 362.

rather than *increase* the costs to the Plan for purchasing health benefits.

The Seventh Circuit's creation of a new fiduciary standard unsupported by ERISA is not a harmless aberration. The *Herdrich* decision can be invoked any time cost-saving mechanisms — the essence of employer-sponsored health care plans and managed care — are in place.⁴² Yet health plan enrollees already have a remedy for inadequate quality of medical services in medical malpractice law.⁴³ The court of appeals' decision in *Herdrich* not only blurs the line between medical malpractice standards and ERISA fiduciary standards, but also constitutes impermissible "judicial policymaking" by disregarding the express policy determinations of Congress, the Executive Branch and state legislatures mandating cost saving measures in health care. Most significantly, it irreparably harms the ability of ERISA fiduciaries, employers, plan administrators, and MCOs to sustain our current system of employer-based health coverage on which millions of Americans depend.

CONCLUSION

For the above reasons, Amici, HIAA, AAHP, APPWP and the Chamber, respectfully request that this Court grant the Petition for Certiorari.

42. *Herdrich* has already been relied upon to allow a breach of fiduciary duty claim against an HMO doctor on the basis of the perceived financial tension between the doctor's and clinic's financial well being and the patient's welfare. See *Neade v. Portes*, 710 N.E.2d 418, 424-25 (Ill. App. Ct. 1999). While *Herdrich* emphasized that it did not intend to open the floodgates of litigation, the *Neade* decision, guided by the authority of *Herdrich*, accomplishes exactly that result.

43. See *DeLucia v. Saint Luke's Hosp.*, No. 98-6446, 1999 U.S. Dist. LEXIS 8124, at *10 (E.D. Pa. May 24, 1999).

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APPENDIX

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**APPENDIX — COMPILATION OF RELEVANT
STUDIES AND ARTICLES**

(Omitted here but submitted separately
as Lodging Appendix)